		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0013862

Facility Name: ST JOSEPH'S HOME OF PEORIA

Address: 2223 WEST HEADING AVENUE (Number) WEST PEORIA (City) 61604 (Zip Code)

County: PEORIA

Telephone Number: (309) 673-7425 **Fax #** (309) 673-7430

IDPA ID Number: 37-0676431

Date of Initial License for Current Owners: UNKNOWN

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SISTER MARY BARBARA BUCKLEY **Telephone Number:** (309) 673-7425

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2002 to 06/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) SISTER MARY BARBARA BUCKLEY
(Title) ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) SEE ATTACHED COMPILATION REPORT
(Firm Name & Address) GINOLI & COMPANY LTD, CPAS, 411 HAMILTON BLVD., STE 1616; PEORIA, IL; 61602-11
(Telephone) (309) 671-2350 Fax # (309) 671-5459

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,695	3
4		Intermediate/DD			4
5	146	Sheltered Care (SC)	146	53,290	5
6		ICF/DD 16 or Less			6
7	189	TOTALS	189	68,985	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	7,537	7,319		14,856	10
11	ICF/DD					11
12	SC	9,048	28,563		37,611	12
13	DD 16 OR LESS					13
14	TOTALS	16,585	35,882		52,467	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.06%

D. How many bed-hold days during this year were paid by Public Aid?
8 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started NOVEMBER 1958

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [N/A] NO [ ]

Tax Year: EXEMPT Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary			826,283	826,283		826,283	(74,562)	751,721			1
2	Food Purchase											2
3	Housekeeping	369,546	37,912	17,807	425,265		425,265	(17,856)	407,409			3
4	Laundry											4
5	Heat and Other Utilities			192,546	192,546		192,546	(11,181)	181,365			5
6	Maintenance	97,274	21,140	37,349	155,763		155,763		155,763			6
7	Other (specify):*											7
8	**TOTAL General Services**	466,820	59,052	1,073,985	1,599,857		1,599,857	(103,599)	1,496,258			8
	B. Health Care and Programs											
9	Medical Director			400	400		400		400			9
10	Nursing and Medical Records	1,483,153	50,291	323,141	1,856,585		1,856,585	(231,357)	1,625,228			10
10a	Therapy	25,277		873	26,150		26,150		26,150			10a
11	Activities	52,366	5,598	6,513	64,477		64,477		64,477			11
12	Social Services	10,060			10,060		10,060		10,060			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,570,856	55,889	330,927	1,957,672		1,957,672	(231,357)	1,726,315			16
	C. General Administration											
17	Administrative			76,600	76,600		76,600		76,600			17
18	Directors Fees											18
19	Professional Services			58,237	58,237		58,237	(1,275)	56,962			19
20	Dues, Fees, Subscriptions & Promotions			10,246	10,246		10,246	(9,005)	1,241			20
21	Clerical & General Office Expenses	42,267	8,576	24,740	75,583		75,583	(5,047)	70,536			21
22	Employee Benefits & Payroll Taxes			395,907	395,907		395,907	(44,355)	351,552			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,467	1,467		1,467		1,467			24
25	Other Admin. Staff Transportation			3,911	3,911		3,911	(1,598)	2,313			25
26	Insurance-Prop.Liab.Malpractice			36,069	36,069		36,069		36,069			26
27	Other (specify):*	28,664	24,572	4,933	58,169		58,169	(58,169)				27
28	**TOTAL General Administration**	70,931	33,148	612,110	716,189		716,189	(119,449)	596,740			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,108,607	148,089	2,017,022	4,273,718		4,273,718	(454,405)	3,819,313			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA #0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			135,044	135,044		135,044	(6,481)	128,563			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			135,044	135,044		135,044	(6,481)	128,563			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	18,462	43,696		62,158		62,158		62,158			41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):*			3,164	3,164		3,164	(3,164)				43
44	**TOTAL Special Cost Centers**	18,462	43,696	26,707	88,865		88,865	(3,164)	85,701			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,127,069	191,785	2,178,773	4,497,627		4,497,627	(464,050)	4,033,577			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(3,243)	27		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,598)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,690)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,275)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(53,236)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,768)	20		28
29	Other-Attach Schedule SISTERS' EXPENSES SEE PG 5A	(388,956)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (454,766)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule SEE PAGE 5A	(9,284)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (9,284)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (464,050)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

ST JOSEPH'S HOME OF PEORIA

ID# 0013862

Report Period Beginning: 07/01/2002

Ending: 06/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	EXPENSE OF INFIRMED AND RETIRED SISTER	$		1
2	LIVING IN CONVENT			2
3	UTILITIES	(11,181)	5	3
4	NURSING SALARIES	(231,357)	10	4
5	EMPLOYEE BENEFITS AND TAXES	(44,355)	22	5
6	OTHER EXPENSES	(3,164)	43	6
7	DEPRECAITION	(6,481)	30	7
8	FOOD	(74,562)	1	8
9	HOUSEKEEPING	(17,856)	3	9
10				10
11	ST. JOSEPH'S HOME HAS BEEN REUMBURSED FOR THE SISTERS' EXPENSES			11
12	BY THE MOTHERHOUSE			12
13				13
14				14
15	GIFTS	(5,047)	21	15
16	NON ALLOWABLE ADVERTISING	(4,237)	20	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(398,240)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(74,562)	0	0	0	0	0	0	0	0	0	0	(74,562)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(17,856)	0	0	0	0	0	0	0	0	0	0	(17,856)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,181)	0	0	0	0	0	0	0	0	0	0	(11,181)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(103,599)	0	0	0	0	0	0	0	0	0	0	(103,599)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(231,357)	0	0	0	0	0	0	0	0	0	0	(231,357)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(231,357)	0	0	0	0	0	0	0	0	0	0	(231,357)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,275)	0	0	0	0	0	0	0	0	0	0	(1,275)	19
20	Fees, Subscriptions & Promotions	(9,005)	0	0	0	0	0	0	0	0	0	0	(9,005)	20
21	Clerical & General Office Expenses	(5,047)	0	0	0	0	0	0	0	0	0	0	(5,047)	21
22	Employee Benefits & Payroll Taxes	(44,355)	0	0	0	0	0	0	0	0	0	0	(44,355)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,598)	0	0	0	0	0	0	0	0	0	0	(1,598)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(58,169)	0	0	0	0	0	0	0	0	0	0	(58,169)	27
28	**TOTAL General Administration**	(119,449)	0	0	0	0	0	0	0	0	0	0	(119,449)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(454,405)	0	0	0	0	0	0	0	0	0	0	(454,405)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **ST JOSEPH'S HOME OF PEORIA** **# 0013862** **Report Period Beginning:** **07/01/2002** **Ending:** **06/30/2003**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,481)	0	0	0	0	0	0	0	0	0	0	(6,481)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,481)	0	0	0	0	0	0	0	0	0	0	(6,481)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(3,164)	0	0	0	0	0	0	0	0	0	0	(3,164)	43
44	**TOTAL Special Cost Centers**	(3,164)	0	0	0	0	0	0	0	0	0	0	(3,164)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(464,050)	0	0	0	0	0	0	0	0	0	0	(464,050)	45

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	TAX EXEMPT	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST JOSEPH'S HOME OF PEORIA COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0013862

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 120,516 B. General Construction Type: Exterior BRICK Frame CEMENT BLOCK, ST Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		566,280	1950	$ 27,936	1
2					2
3	TOTALS	566,280		$ 27,936	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	194		1958	12/31/1958	$ 2,132,689	$ 42,654	50	$ 42,654	$	$ 1,895,445	4
5			1979	12/31/1979	10,889		50			10,889	5
6			2001	3/12/2001	4,836	242	50	242		565	6
7											7
8											8
	Improvement Type**										
9	BLDG IMPROVEMENTS			12/31/1974	11,596		15			11,596	9
10	BLDG IMPROVEMENTS			12/31/1975	6,540		15			6,540	10
11	BLDG IMPROVEMENTS			12/31/1976	3,731		15			3,731	11
12	BLDG IMPROVEMENTS			12/31/1977	1,333		15			1,333	12
13	BLACKTOPPING			12/31/1978	35,175		15			35,175	13
14	BLDG IMPROVEMENTS			12/31/1979	23,573		10			23,573	14
15	SEALER WORK			12/31/1980	4,080		5			4,080	15
16	CONVERT B WING			12/31/1982	23,832		15			23,832	16
17	SHOWERS, ROOF			12/31/1983	10,862		15			10,862	17
18	BUSHES			12/31/1983	1,928		5			1,928	18
19	ROOFING, FIREWALL, ETC.			12/31/1984	42,124		15			42,124	19
20	PHONE SYSTEM			12/31/1984	7,600		10			7,600	20
21	ROOFING, PLUMBING, TILE			12/31/1985	60,141		15			60,141	21
22	BLDG IMPROVEMENTS			12/31/1986	124,144		15			124,144	22
23	BLDG IMPROVEMENTS			12/31/1987	152,500	4,215	15	4,215		151,638	23
24	BLDG IMPROVEMENTS			12/31/1988	21,760	1,451	15	1,451		21,039	24
25	PARKING LOT			12/31/1988	6,334		5			6,334	25
26	CARPETING			12/31/1989	1,391		10			1,391	26
27	LIGHTS, POLES, INSTALL			12/31/1989	4,809	321	15	321		4,173	27
28	REPLACE WATER HEATERS			12/31/1989	36,519	2,445	15	2,435	(10)	31,655	28
29	BLDG IMPROVEMENTS			12/31/1990	24,321	1,621	15	1,621		20,263	29
30	BLDG IMPROVEMENTS			12/31/1990	5,218		10			5,218	30
31	BATHROOM REMODEL			12/31/1991	5,837	389	15	389		4,473	31
32	BATHROOM REMODEL			10/31/1992	5,954	397	15	397		4,233	32
33	BATHROOM REMODEL			9/30/1992	3,833	256	15	256		2,751	33
34	INSTALL 2 SHOWERS			9/30/1992	4,556	304	15	304		3,267	34
35	REPLACE DOORS			2/28/1993	2,195	146	15	146		1,509	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BEAUTY SHOP IMPROVMENTS	6/1/1994	$ 1,296	$ 86	15	$ 86	$	$ 781	37
38	PHOTO EYE AND LAMP	6/1/1994	2,185	146	15	146		1,326	38
39	ASBESTOS REMOVAL	6/30/1990	19,985		18	1,110	1,110	14,431	39
40	SODIUM LIGHTS	2/14/1995	3,505	234	15	234		1,969	40
41	REMODEL SHOWERS	8/31/1995	13,703	914	15	914		6,855	41
42	ALARM SYSTEM	7/1/1996	3,103	443	7	443		3,101	42
43	CARPET	1/30/1997	500	71	7	71		456	43
44	ROOF	12/9/1997	90,018	9,002	10	9,002		50,261	44
45	ASBESTOS REMOVAL AND PLUMBING	11/29/1997	18,500	925	20	925		5,165	45
46	ASBESTOS REMOVAL AND PLUMBING	4/17/1998	19,800	990	20	990		5,115	46
47	LAMPS	12/9/1997	16,817	2,402	7	2,402		13,329	47
48	WINDOWS	8/31/1998	1,903	95	20	95		467	48
49	NEW SEWER LINE TO GREASE PIT	2/28/1999	1,730	173	10	173		764	49
50	NEW PIPESAND REPAIRS	3/31/1999	839	84	10	84		364	50
51	TILES AND FLOORING	4/20/1999	1,950	195	10	195		829	51
52	ALARM SYSTEM	4/30/1999	13,729	915	15	915		3,889	52
53	PAVE PARKING LOT	5/25/1999	64,959	8,120	8	8,120		33,833	53
54	REMOVE WALL AND PUT IN DOOR	11/2/1998	1,050	70	15	70		327	54
55	REMOVE WALL AND PUT IN DOOR	3/24/1999	1,350	90	15	90		390	55
56	SIDEWALKS	6/3/1999	4,440	296	15	296		1,208	56
57	PARKER BATH WITH ELECTRIC ADJUSTMENTS	1/17/2000	8,900	890	10	890		3,115	57
58	LATH AND PLASTER REPAIRS	1/29/2000	1,536	154	10	154		539	58
59	BATH REMODLE	1/5/2000	877	88	10	88		308	59
60	LIGHT FIXTURES	3/17/2000	413	41	10	41		137	60
61	TILE REPAIR IN WASHTUB AREA	4/4/2000	1,369	137	10	137		445	61
62	CARPET	6/19/2000	659	66	10	66		203	62
63	CARPET	1/31/2000	525	52	10	52		182	63
64	4' X8' TWO-SIDED SIGN AND POSTS	1/17/2000	1,800	180	10	180		630	64
65	SIDEWALKS	6/1/2000	2,200	147	15	147		453	65
66	ASBESTOS REMOVAL	9/15/2000	12,500	625	20	625		1,771	66
67	FIXTURES	10/31/2000	9,291	929	10	929		2,477	67
68	CARPET	5/31/2001	705	70	10	70		146	68
69	WROUGHT IRON FENCE AND GATES	8/8/2000	1,175	78	15	78		228	69
70	TOTAL (lines 4 thru 69)		$ 3,103,612	$ 83,149		$ 84,249	$ 1,100	$ 2,676,996	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,103,612	$ 83,149		$ 84,249	$ 1,100	$ 2,676,996	1
2	FIRE ALARM SYSTEM	10/12/2001	11,850	790	15	790		1,383	2
3	FIRE ALARM SYSTEM	11/20/2001	5,388	359	15	359		569	3
4	LIGHT FIXTURES	2/1/2002	1,171	117	10	117		166	4
5	VENTILATORS	3-Jul	7,987	532	15	532		1,064	5
6	CARPET	11/21/2001	1,200	120	10	120		190	6
7	CARPET	9/13/2001	707	71	10	71		130	7
8	CARPET	12/12/2001	800	80	10	80		127	8
9	PLASTER WORK	1/11/2002	166	17	10	17		25	9
10	PLASTER WORK	11/23/2001	877	88	10	88		139	10
11	CERAMIC TILE WORK	4/25/2002	1,000	100	10	100		117	11
12	SEWER AND PIPE REPAIR	4/30/2002	20,698	2,070	10	2,070		2,415	12
13	C WING ROOF REPAIR	3/14/2002	3,277	218	15	218		291	13
14	LINOLEUM FLOOR	4/10/2002	1,080	108	10	108		135	14
15	CARPET	4/24/2002	732	73	10	73		85	15
16	ROOF REPAIR	4/30/2002	2,388	159	15	159		186	16
17	BATHROOM PLASTERING	5/3/2002	531	53	10	53		62	17
18	ROOF REPAIR	11/30/1998	2,162					2,162	18
19	ROOF REPAIR	3/31/1999	3,230					3,230	19
20	PLASTER REPAIR	4/3/1999	9,698	970		970		4,121	20
21	ROOF REPAIR	11/23/2002	2,935	163		163		163	21
22	TILE WORK	2/20/2003	925	31		31		31	22
23	9 WINDOWS AND INSTALLATION	6/11/2003	2,860	24		24		24	23
24	INSTALL SMOKE ALARMS	5/21/2003	2,100	12		12		12	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,187,374	$ 89,304		$ 90,404	$ 1,100	$ 2,693,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 298,045	$ 30,879	$ 30,879	$		$ 166,799	71
72	Current Year Purchases	47,837	3,596	3,596			3,596	72
73	Fully Depreciated Assets	479,988					525,790	73
74								74
75	TOTALS	$ 825,870	$ 34,475	$ 34,475	$		$ 696,185	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	LONG-TERM CARE	1993 CHEVY LUMINA	1995	$ 15,202	$	$	$		$ 15,202	76
77	LONG-TERM CARE	1997 FORD ESCORT	1996	15,279					15,279	77
78	LONG-TERM CARE	2002 CHEVY TRUCK	2002	22,104	3,684	3,684			3,684	78
79										79
80	TOTALS			$ 52,585	$ 3,684	$ 3,684	$		$ 34,165	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,093,765	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 127,463	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,563	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,100	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,424,173	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	RETIRED SISTERS CONVENT	$ 288,400	$ 7,210	$ 227,115	86
87	WORKING SISTERS HOUSED IN HOME				87
88	PORTION OF DEPRECIATION		5,040		88
89	CARPETING IN RETIRED SISTERS CO	2,964	371	1,762	89
90					90
91	TOTALS	$ 291,364	$ 12,621	$ 228,877	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 89,134	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	166,364		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,230		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DEFERRED EXPENSE S/T	571		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 292,299	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	468,729		12
13	Land	153,532		13
14	Buildings, at Historical Cost	3,328,100		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	908,197		16
17	Accumulated Depreciation (book methods)	(3,639,278)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	520,956		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEFERRED EXPENSE L/T	1,972		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,742,208	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,034,507	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 144,250	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,557		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 246,807	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 246,807	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,787,700	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,034,507	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,511,958	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,511,958	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(724,258)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (724,258)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,787,700	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,270,024	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,270,024	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	42,871	12
13	Barber and Beauty Care	3,514	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	172	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	62	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 46,619	23
	D. Non-Operating Revenue		
24	Contributions	123,713	24
25	Interest and Other Investment Income***	(46,949)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 76,764	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		379,962	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 379,962	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,773,369	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,599,857	31
32	Health Care	1,957,672	32
33	General Administration	716,189	33
	B. Capital Expense		
34	Ownership	135,044	34
	C. Ancillary Expense		
35	Special Cost Centers	65,322	35
36	Provider Participation Fee	23,543	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,497,627	40
41	**Income before Income Taxes (line 30 minus line 40)****	(724,258)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (724,258)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** TAX EXEMPT **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,101	2,272	$ 51,842	$ 22.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,483	10,031	160,239	15.97	3
4	Licensed Practical Nurses	26,180	29,398	439,521	14.95	4
5	Nurse Aides & Orderlies	55,038	61,277	600,194	9.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,853	2,237	25,277	11.30	8
9	Activity Director	1,855	1,958	21,114	10.78	9
10	Activity Assistants	4,068	4,237	31,252	7.38	10
11	Social Service Workers	891	905	10,060	11.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,708	7,524	97,274	12.93	17
18	Housekeepers	35,707	40,067	351,690	8.78	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,910	2,142	28,664	13.38	22
23	Office Manager					23
24	Clerical	4,190	4,547	42,267	9.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SNACK BAR	1,789	2,012	18,462	9.18	33
34	TOTAL (lines 1 - 33)	151,773	168,607	$ 1,877,856 *	$ 11.14	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	4	400	L9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	19	873	L10A	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,047	L11	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	53	$ 2,320		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	114	$ 4,002	L10C3	50
51	Licensed Practical Nurses	3,698	105,676	L10C3	51
52	Nurse Aides	4,838	78,199	L10C3	52
53	TOTAL (lines 50 - 52)	8,650	$ 187,877		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
SISTER MARY DRIES, CO-ADMINISTRATOR	$ 38,300
SISTER MARY PAUL MAZZORANA, CO-ADMINISTRATOR	38,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 76,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
GINOLI & COMPANY	ACCOUNTING	$ 8,674
HONKAMP KRUEGAR	PAYROLL	5,682
BANK KOE SYSTEM	TIMEKEEPING	1,436
CLIFTON GUNDERSON	COMPTER SERVICES	935
MARK REESE	COMPTER SERVICES	225
CB RETIREMENT	ACCOUNT MANAGEMENT	532
MANAGEMENT PERFORMANCE	OPERATIONS SURVEY	30,000
ROGER QUICK	COMPTER SERVICES	75
MARGOT DUVAL	CPR TRAINING	550
INDUSTRIAL DATA	COMPTER SERVICES	7,372
ACHIEVE HEALTCARE	COMPTER SERVICES	1,481
EMPLOYEE ASSOCIATES	LEGAL	1,275
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 58,237

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,566
Unemployment Compensation Insurance	
FICA Taxes	139,496
Employee Health Insurance	133,040
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PROFESSIONAL LIABILITY INSURANCE	20,450
TOTAL (agree to Schedule V, line 22, col.8)	$ 351,552

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,237
Health Care Worker Background Check	276
(Indicate # of checks performed 23)	
YELLOW PAGES ADVERTISING	4,768
STATE LICENSES	161
PEORIA CITY/COUNTY PUBLIC HEALTH	150
INHAA, HIPAA, EMPLOYERS ASSOC	435
SAMS CLUB	30
SUBSCRIPTIONS	189
Less: Public Relations Expense	( )
Non-allowable advertising	(4,237)
Yellow page advertising	(4,768)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,241

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,467
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,467

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	REPAIR TEMP CNTRL	09/04/98	$ 784	5	$ 157	$ 157	$ 157	$ 157	$	$	$	$	$
2	REPAIR HEAT EXCHAN	04/28/99	651	3	217	217	163						
3	PLUMBING REPAIRS	08/31/99	4,137	10	379	414	414	414					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,572		$ 753	$ 788	$ 734	$ 571	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **INHAA $75**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **YES** If YES, what is the capacity? **187**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **12**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,242** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **23,543**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **YES** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **6%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number ST JOSEPH'S HOME OF PEORIA # 0013862 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

SCHEDULE V

PAGE 3, LINE 27 - GENERAL ADMINISTRATION

SALARY/WAGE	
FUND DIRECTOR	28,664
SUPPLIES	
DEVELOPMENT EXPENSE	24,572
OTHER	
IPAC REFUNDS	3,243
PENALTIES	1,690
TOTAL PAGE 3, LINE 27, COL 3	58,169

PAGE 4, LINE 43 - SPECIAL COST CENTERS

SALARY/WAGE	
SUPPLIES	
OTHER	
EXPENSES OF SISTERS ON STAFF	
DUES, MEMBERSHIPS, AND SUB	454
MEDICAL AND DENTAL	92
HOUSE SUPPLIES	311
GIFTS	25
EXPENSES OF RETIRED SISTERS LIVING IN BUILDING	
MEDICAL AND DENTAL	388
HOUSE SUPPLIES	1,894
TOTAL PAGE 4, LINE 43, COL 3	3,164

ST. JOSEPH'S HOME HAS BEEN REIMBURSED FOR THE SISTERS' EXPENSES BY ITS MOTHERHOUSE

SCHEDULE XVIII

PAGE 20, LINE 34

TOTAL DOES NOT AGREE WITH SCHEDULE V, PAGE 3, LINE 45, COL 1 BECAUSE THE TOTAL ON PAGE 4 INCLUDES $249,213 FOR WAGES OF PERSONNEL WHO WORK WITH THE INFIRMED AND RETIRED SISTERS WHICH IS REIMBURSED TO THE HOME BY OUR COMMUNITY. THE COST OF THESE WAGES IS ADJUSTED ON PAGE 3.

PAGE 20, LINE 20

THE ADMINISTRATOR'S POSITION IS FILLED BY RELIGIOUS WHO RECEIVE NO PERSONAL REMUNERATION, BUT WHOSE EVALUATED SERVICES HAVE BEEN INCLUDED ON PAGE 3, LINE 17, COL 3.

RECONCILIATION OF DEPRECIATION EXPENSE

	COL 4	ADJUST	COL 8
SCHEDULE V, LINE 30	135,044	(6,481)	128,563
NON-CARE ASSETS DEPRECIATION	(12,621)	12,621	0
ADJUSTMENTS TO STRAIGHT LINE DEPRECIATION		(1,100)	0
WORKING SISTERS HOUSED IN HOME PORTION OF DEPRECIATION	5,040	(5,040)	0
SCHEDULE XI, PAGE 13, SEC E LINE 82	127,463		
SCHEDULE XI, PAGE 13, SEC E LINE 83		0	128,563